STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445476	A. BUILDING _____ B. WING _____	06/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND HOME PARK HEALTH AND REHAB	1758 HILLWOOD DRIVE KNOXVILLE, TN 37920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey and investigation of complaints (#36250 and 35678) were conducted from 06/08/15, through 06/10/15 at Island Home Park Health And Rehab. No deficiencies were cited in relation to the complaints (#36250 and 35678) under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000	**Disclaimer** **This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.** **taken:**	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to develop a comprehensive care plan for Dental Care for 1	F 279	**F279** Comprehensive Care Plan for Resident #30 was updated to address dental status by the Minimum Data Set Coordinator on 6/9/15. All resident Care Plans were reviewed for inclusion of dental status by the Minimum Data Set Coordinator on 6/26/15. No other residents were affected. Minimum Data Set Coordinator was re-educated by the Director of Nursing regarding the need to address dental status on each Care Plan on 6/10/15. All resident Care Plans will be reviewed by the Director of Nursing or Assistant Director of Nursing during scheduled Care Plan meetings to assure dental status has been addressed and updates will be made as needed.	7/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marion Hansen	Administrator	6/25/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

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F 279	Continued From page 1 Resident (#30) of 2 residents reviewed for Dental Status, of 30 residents reviewed. The findings included: Observation of Resident #30, on 6/9/15, at 8:00 AM, in the resident's room, revealed the resident was missing all of her top teeth and several of her bottom teeth. Medical record review revealed Resident #30 was admitted on 8/18/06, with diagnoses of Senile Dementia, Atrial Fibrillation, Macular Degeneration, Alzheimer's Disease, Congestive Heart Failure, and Dementia. Medical record review of Resident #30's comprehensive care plan dated 4/13/15, revealed there had been no care plan developed addressing Resident #30's dental status. Interview with the Director of Nursing (DON) on 6/10/15 at 10:31 AM, in the DON's office, confirmed the facility had failed to develop a care plan to address Resident #30's dental status.	F 279	Results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the action plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	F309 Physician's order for placement of indwelling urinary catheter and corresponding catheter care for Resident #137 was obtained by Director of Nursing on 6/9/15. All residents with indwelling urinary catheters were evaluated and their charts reviewed for appropriate orders by the Director of Nursing on 6/10/15. All residents' physician orders for indwelling urinary catheter were found to be in compliance.	7/30 2015

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F 309	Continued From page 2 by: Based on review of facility policy, medical record review, observation, and interview, the facility failed to obtain a physician's order to place an indwelling urinary catheter for one resident (#137) of 2 residents reviewed for indwelling urinary catheters, of 30 residents reviewed. The findings included: Review of the facility policy Physician's Orders revealed "...All treatments and medications must be ordered, signed and dated by the resident's attending physician...Physician orders include:...f) Special medical procedures required for the safety and well being of the resident...NOTE: Medications, diets, therapy, or any treatment may not be administered to the resident without a written order from the attending physician..." Medical record review revealed Resident #137 was admitted to the facility on 6/2/15, with diagnoses including Alcohol Cirrhosis, Anxiety State, and Encounter Palliative Care. Continued review revealed Resident #137 was admitted to Hospice Care on 6/6/15. Medical record review of the Physician's Orders for Resident #137 failed to reveal an order to place an indwelling urinary catheter. Observation of Resident #137 on 6/8/15, at various times from 9:30 AM, to 4:45 PM, on 6/9/15, from 8:00 AM to 4:30 PM, and on 6/10/15, from 7:30 AM to 1:00 PM, in the resident's room revealed the resident lying in the bed and unresponsive to verbal or physical stimuli. Continued observation revealed an indwelling urinary catheter with a small amount of light	F 309	The Director of Nursing notified the Hospice Director regarding failure to obtain physician orders for hospice patient on 6/9/15. Hospice Care Plan meeting was held by Assistant Director of Nursing and Minimum Data Set Coordinator with the Hospice Nursing Coordinator to review all hospice patients and their physician orders on 6/18/15. Director of Nursing, Assistant Director of Nursing, Medical Director met with Hospice Director to clarify and re-educate regarding facility policy regarding physician orders for hospice patients on 6/25/15. The charts of all new hospice admissions will be reviewed at daily weekday morning meetings by the Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator and/or Unit Manager for appropriate physician orders are present. On weekends and holidays the nursing manager on duty or Unit Manager will review charts of any new hospice admissions to assure appropriate physician orders are present. The Director of Nursing and/or the Minimum Data Set Coordinator will review all hospice admission charts weekly x 4 weeks, then monthly x 2 months and/or 100% compliance. Results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the action plan.	

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F 309	Continued From page 3 yellow urine in the urine collection bag. Interview with the Director of Nursing (DON) and the Corporate Nurse Consultant on 6/9/15, at 12:45 PM, in the DON's office, confirmed a Hospice nurse placed the indwelling urinary catheter in Resident #137 on 6/6/15, and failed to obtain a physician's order from the attending physician.	F 309	Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on review of facility policies, review of the daily cleaning log, review of the Weekly Cleaning Schedule-Deep Fryer, observation and interview, the facility failed to maintain a sanitary kitchen by not properly cleaning the deep fryer and the stationary can opener, by failure to use opened three bean salad and tapioca pudding by the use by dates, by failing to maintain safe milk temperatures for one of four milks, and by failure to remove a build up of dust particles on a duel cooling fan for one of one walk-in freezer, for one of one kitchen reviewed.	F 371	**F371** The deep fryer and stationary can opener were cleaned by Dietary Manager on 6/8/15. The three bean salad dated 6/2/15 and the tapioca pudding dated 6/1/15 were discarded by Dietary Manager on 6/8/15. The carton of whole milk was discarded by Dietary Manager on 6/8/15. The cooling fan in the walk in freezer was cleaned by the Facilities Management Director on 6/8/15. All food items stored in refrigerators were evaluated by the Dietary Manager to assure no items were retained past acceptable use date on 6/8/15. No other items were found to be affected. All Dietary employees were re-educated by Dietary Manager on the cleaning schedule, timely discarding of leftovers, and ensuring appropriate temperature of milk on 6/15/15.	7/30 2015

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F 371	Continued From page 4 The findings included: Review of the facility policy, General Food Preparation and Handling, dated 2009, revealed "...all food service equipment should be cleaned, sanitized...after each use..." Review of the facility policy, Can Opener, updated 9/2011, revealed "...sanitation of equipment...frequency...after each meal..." Review of the facility policy, Deep-Fat Fryer, updated 9/2011, revealed "...cleaning/sanitation of equipment...frequency: after each use..." Review of the Trayline Refrigerated Leftover Storage policy, updated 9/2011, revealed "...date container with use by date...pudding...1-2 days..., salads-marinated...1 to 3 day storage..." Further review revealed "fresh milk... at 41 degrees F (Fahrenheit) or less..." Review of the Daily Cleaning Log, dated 6/1 through 6/7, 2015, revealed the can opener cleaning frequency "each use". Review of the Weekly Cleaning Schedule, Deep Fryer, dated 5/31 to 6/6, 2015, revealed the deep fryer cleaning frequency "weekly". Observation with the Certified Dietary Manager (CDM), on 6/8/15, at 8:05 AM, in the kitchen, revealed a covered deep fryer containing brown grease with floating brown crumbs in and around the rim. Observation with the CDM, on 6/8/15, at 8:15 AM, at the Number 3 Reach-In Cooler, revealed a tub of opened tapioca pudding, dated "6/1" and a tub	F 371	A preventive maintenance schedule for cleaning cooling fans was developed by the Facilities Management Director on 6/10/15. The Dietary Manager and/or Cook will evaluate the can opener and deep fryer for cleanliness daily for 1 week, then 3x a week for 3 weeks then 1x a week for 2 months and/or 100% compliance. The Dietary Manager and/or Cook will audit refrigerators for properly dated food items daily for 1 week, then 3x a week for 3 weeks then 1x a week for 2 months and/or 100% compliance. The Dietary Manager and /or Cook will evaluate milk temperatures on the buffet daily for 1 week, then 3x a week for 3 weeks then 1x a week for 2 months and/or 100% compliance. The Facilities Management Director will inspect the cooling fan in the walk in freezer weekly for one month to assure no dust build up has occurred, then once a month for 2 months and/or 100% compliance. Results obtained will be reported by the Dietary Manager and Facilities Maintenance Director to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the action plan.	

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F 371	Continued From page 5 of opened three-bean salad, dated "6/2". Observation with the CDM, on 6/8/15, at 8:25 AM, at the kitchen stationary can opener, revealed dried food and paper particles on the shank and blade of the can opener. Observation with the CDM, on 6/8/15, at 8:30 AM, of milk on ice in a basin, for the breakfast buffet, revealed a carton of whole milk with a temperature of 48 degrees F. Observation with the CDM, on 6/8/15, at 8:45 AM, in the freezer walk-in, revealed dust particles on the duel cooling fans. Interview with the CDM, on 6/8/15, at 8:50 AM, in the kitchen, confirmed the deep fryer had been used on Friday (6/5), the tub of opened tapioca pudding, dated "6/1" and the tub of opened three-bean salad, dated "6/2" should have been discarded, the stationary can opener "...should have been cleaned...", and the whole milk was too warm. Continued interview confirmed the build up of the dust particles on the duel cooling fans. Interview with the Maintenance Manager, on 6/10/15, at 1:40 PM, in the maintenance hallway, confirmed "...there is no preventative maintenance program for cleaning the walk-in freezer..."	F 371	Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	**F441** CPAP masks and tubing for Resident # 135 and Resident #134 were cleaned by the Assistant Director of Nursing on 6/9/15. No other residents had physician orders for CPAP masks.	7/30 2015

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F 441	Continued From page 6 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to develop a policy for the care and cleaning of contaminated, reusable CPAP	F 441	Resident # 134 discharged from the facility on 6/11/15 and Resident #135 discharged from the facility on 6/18/15. Policy and procedure for cleaning CPAP mask and tubing was implemented by the Director of Nursing on 6/9/15. Licensed nurses were educated on cleaning procedure by the Director of Nursing and the Assistant Director of Nursing on 6/9/15, 6/10/15 and 7/2/15. Cleaning schedule for CPAP masks and tubing was placed on the Medication Administration Records of Resident # 134 and Resident #135 for weekly nursing documentation. The Director of Nursing and/or the Assistant Director of Nursing will review the Medication Administration Records of all residents with physician orders for CPAP masks weekly x 4 weeks, then monthly x 2 months and/or 100% compliance. Results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the action plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	

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F 441	Continued From page 7	F 441		

(Continuous Positive Airway Pressure) (for the use of maintaining respirations while asleep) equipment to maintain infection control, for 2 residents (#135, #134), of 2 residents reviewed using CPAP equipment, of 30 residents reviewed.

The findings included:

Medical record review revealed Resident #135 was admitted to the facility on 5/22/15 with diagnoses including End Stage Renal Disease with Renal Dialysis, Acute Respiratory Failure, Obstructive Sleep Apnea, and Sepsis.

Observation of Resident #135, on 6/9/15, at 9:30 AM, in the resident's room, revealed an uncovered CPAP mask and tubing laying in a basin, on the side table next to the resident's bed.

Medical record review revealed Resident #134 was admitted to the facility on 5/26/15, with diagnoses including Sleep Apnea (periods of no breathing).

Observation of Resident #134 on 6/8/15, at 3:30 PM, and on 6/9/15, at 9:30 AM, and at 2:00 PM, in Resident #134's room revealed the resident's CPAP machine on the over the bed table with the mask uncovered.

Interview with Resident #134 on 6/8/15, at 4:00 PM, in Resident #134's room, revealed the facility staff had not cleaned the CPAP mask since the resident had been admitted to the facility.

Interviews with Registered Nurse #1, Licensed Practical Nurses (LPN) #1, LPN #2, Certified Nursing Assistants (CNA) #3, #4, #5, #6, and #7, from 6/9/15 to 6/10/15, and over day and evening

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F 441	Continued From page 8 shifts, confirmed no training or instructions on the care of the CPAP equipment had been given to the staff by the facility. Continued interview confirmed the staff did not clean the CPAP equipment. Interview with the Administrator, on 6/9/15, at 10:00 AM, at the nursing station, confirmed the facility had failed to develop a policy for the proper care and cleaning of the CPAP equipment.	F 441		